Rhode Island Commission on Women

Position Paper on the Health Care Response to Domestic Violence[1]

The Rhode Island Commission on Women views domestic violence as a significant public health issue needing to be addressed by the health care community. The Commission believes that all community institutions including health care must work together to increase safety for domestic violence victims, to respect their autonomy, and to hold perpetrators, not victims, accountable for stopping the abuse.

Domestic violence is a pattern of assaultive and coercive behaviors in which a person is harmed or threatened by a family member, household member or intimate partner. In 95% of cases, these crimes are committed by men against women, and one in four women is likely to be abused by an intimate partner in her lifetime[2]. In Rhode Island during 1999, police responded to 6,932 domestic violence calls. During the year 2000, member agencies of the RI Coalition Against Domestic Violence provided services to 9,121 unduplicated victims of domestic violence and responded to 19,719 hotline calls[3].

Domestic violence is a significant public health issue. More than one-third of all visits to emergency rooms by women with violence-related injuries involve domestic violence[4],[5]. In addition to injuries and fatalities, violence against women results in sleep disorders, unwanted pregnancies, sexually transmitted diseases, miscarriages, gastrointestinal problems, and other chronic medical problems. It leads to mental health issues such as post-traumatic stress disorder, anxiety, depression, low self-esteem and a loss of independence.

Abuse by intimate partners or family members can, and does, occur at any age. Because many elderly women are socially isolated and physically vulnerable, the abuse they experience is often hidden. It has been estimated that only 1 of 14 incidents among elders is reported.[6],[7]

Health care providers are well positioned to identify and address domestic violence. The Rhode Island Department of Health[8], as well as national organizations such as the American Public Health Association[9] have called for increased training for providers and increased screening of patients for domestic violence. Since domestic violence often occurs in private and worsens over time, it can go undetected for long periods. Health care providers are generally the first point of institutional contact for abused women, before they become involved with the law enforcement and criminal justice or shelter systems. *Health care providers have a remarkable opportunity to intervene in early stages, before the violence escalates to serious or fatal injuries*[10].

Yet, despite the critical role health care providers can play in identifying domestic violence and increasing safety by making appropriate referrals, a large body of evidence indicates that few providers take the first step of screening for domestic abuse, even when signs and symptoms are present[11]. There are many reasons. Some providers do not know how to screen for domestic abuse; some view it as a social problem not a health care issue; some feel there is no time to address the issue; and some fear uncovering domestic abuse because they do not know how to help.

In Rhode Island, information from Emergency Department surveys and other studies led to new programs such as an on-call Hospital Advocates program for domestic violence and sexual assault[12]. Despite these new programs and wider understanding of the negative consequences of abuse, Rhode Island's health care professionals still do not routinely screen their patients for domestic violence. Health professions education programs still do not systematically teach all new practitioners to screen for, appropriately refer for, and understand the effects of domestic violence on health. If they did, the health care system could play a primary role in preventing domestic violence.

The Commission supports education on domestic violence for all health professions. Both student training and continuing education for professionals should support providers in understanding how to appropriately screen for, identify and refer patients for issues of domestic abuse. Some health care curricula already include this information, but these are not systematically implemented. A CDC study found that most medical schools spend less than 1.5 hours on domestic violence education over the entire course of medical school[13]! Such education should be a substantial and mandatory component of the curriculum for all health care professionals in Rhode Island. All health care providers should learn how to ask about abuse, how to respond when it is identified, and how to address issues of safety and autonomy for their patients.

The Commission supports routine screening of all female patients aged 14 years and older for domestic abuse. Health care professionals, including physicians and nurses, should screen patients for domestic violence, not only when there is evidence of injury, but as an integral part of routine exams. When physical abuse is detected in children, mothers should be screened as well, because 50-70% of men who abuse their female partners also physically abuse their children[14],[15].

There is evidence that screening can increase identification of victims by nearly 100 percent[16]. Protocols for appropriate screening -- direct, conversational, private and culturally sensitive – should be widely adopted. Protocols published by well-respected national organizations such as the Family Violence Prevention Fund (1999) are already available[17].

Third party payers, including managed care, are now a critical component of our health care system. Increasingly, providers cannot make decisions about care without considering the likelihood that third party payers will approve their decisions. Thus, third party payers, particularly managed care companies, can have enormous influence on the actions of employers and healthcare providers[18]. *Managed care plans need to be convinced that the costs of unidentified and untreated domestic violence make provider training and routine screening essential.*

The Commission supports universal access to interventions to address domestic violence. Screening alone cannot be effective unless backed up by readily available services. There is a need for more available mental health care, advocacy and victim support services, in addition to caring for the physical effects of domestic violence. Health care practitioners should be able to provide all patients with local, culturally appropriate referrals and resources for domestic violence. Health facilities should make written information available in ways that allow women at risk to easily and privately obtain them. Practitioners must address the risk of reprisal and the need for safety precautions. Effective policies and protocols are needed to support practitioners in these efforts.

We do not, however, advocate mandatory reporting by providers of individually identifiable domestic violence injuries to police or courts (unless child or elderly abuse is involved). Such requirements could result in inadequate care or further injury. Victims may delay seeking needed treatment or conceal the cause of an injury if they fear that disclosing abuse to the doctor, and, ultimately, the authorities, will lead an abuser to retaliate. Mandatory reporting also infringes on patient autonomy. Currently, Rhode Island law requires providers to report victim injuries to the Domestic Violence Training and Monitoring Unit of the RI Supreme Court, but the victim is not identified and police are not notified. Its purpose is to track injuries without compromising safety or care of the victim. (However, there is little evidence this law is followed by providers). Each woman, in collaboration with her provider, is the best judge of how safe it is to report the violence. Instead of reporting abuse to the police, it is critical for health care providers to confidentially document screening outcomes while encouraging the woman to seek other assistance.

Domestic violence is not only a woman's problem. It is a societal problem that perpetuates itself across generations. Children witnessing domestic violence can learn to accept abuse as normal or expected in a relationship, and be involved in abusive relationships as adults[19]. Today's domestic violence will negatively affect our society in the future. The Commission encourages managed care payers, health care institutions, education programs and individual practitioners to improve the responsiveness of the health care system to identifying and addressing domestic violence, to help break the cycle of violence for individual women and the transfer of violence across generations.

[1] Adopted by the Rhode Island Commission on Women on December 5, 2001. Developed through the RICW Health Committee.

[2] Glazer, S., Violence Against Women, 3 CQ Researcher 171, Feb.1993, reprinted in *Battered Women: The Facts.* National Center on Women & Family Law, 1996.

[3] Data from the Rhode Island Coalition Against Domestic Violence.

[4] U.S. Department of Justice. August, 1997.

[5] Olson L., et al., "Increasing Emergency Physician Recognition of Domestic Violence." *American College of Emergency Medicine*, 1996.

[6] Pillemer, K. and Finkelhor, D. The prevalence of elder abuse: A random sample survey. *The Gerontologist*, 28:51-57.

[7] A helpful local resource is a booklet "*The Elder Victim's Introduction to the Criminal Justice System*", published by the RI Department of the Attorney General in collaboration with the RI Department of Elderly Affairs and RI Housing.

[8] Verhoek-Oftedah, W, et al., Public Briefings: RI Department of Health: Poor ascertainment of violence against women hampers surveillance. *Medicine and Health / Rhode Island*, 79 (3), 113-115, March 1996.

[9] Policy Statement 9211: Domestic Violence. *American Journal of Public Health*, 83 (3), 458-463, March 1993.

[10] Buckser, D.A. *The Role of Managed Care Plans for Preventing Domestic Violence*. Chapter 3: Health care providers and domestic violence. Masters Thesis, Yale University, 1996. Verhoek-Oftedahl, et al., ibid.

[11] Multiple studies cited in Buckser, 1996, p. 12.

[12] Verhoek-Oftedahl, et al., ibid.

[13] Buel, S. Family violence: Practical recommendations for physicians and the medical community. *Women's Health Issues.* 5 (4), 158-172, 1995. Cited in Buckser, 1996, p. 41.

[14] Bowlker, L.H., ibid.

[15] Straus, M., et al., *Physical Violence in American Families*. New Brunswick: Transaction Pub. 1990.

[16] Olson, L., et al., ibid.

[17] Family Violence Prevention Fund. *Preventing Domestic Violence: Clinical Guidelines on Routine Screening.* FVPF: San Francisco, CA. 1999.

[17] Family Violence Prevention Fund. *Preventing Domestic Violence: Clinical Guidelines on Routine Screening*. FVPF: San Francisco, CA. October 1999.

[18] Buckser, D.A., ibid.

[19] Bowker, L. H., "On the Relationship Between Wife Beating and Child Abuse", in *Feminist Perspectives on Wife Abuse*, 158,164, 1988.